FOR OFFICE USE ONLY

REG NUMBER: _____

DATE: _____

KANSAS STATE BOARD OF PHARMACY
800 SW JACKSON, ROOM 1414
TOPEKA, KS 66612
(785) 296-4056
FAX (785) 296-8420

FEE: 25.00

APPLICATION FOR INSTITUTIONAL DRUG ROOM

This application is being made for the following reason: (check all that apply):

_____New _____Change of Address _____Change of Ownership _____Change of PIC

Previous Kansas License Number (if applicable)_____

_____
Owner Name

_____
Owner Address

_____
City State Zip County Phone No.

_____
Name of Institutional Drug Room

_____
Physical Address

_____
City State Zip County Phone No.

_____
E-Mail Address

_____
Mailing Address for Renewal Information, **IF DIFFERENT** than the physical location.

_____
City State Zip

Type of ownership is : ___ Individual ____ Partnership ____ Corporation
IF PARTNERSHIP, provide list of names and percentage with application.
IF CORPORATION, provide list officers and owners of stock with application.

_____
Name of Responsible Pharmacist of Practitioner Lic. No.

Attach a list of other pharmacists/practitioners who work at the facility as well as their license numbers.

Total hours per week pharmacist on duty in facility: _____ (total hours)

RESPONSIBLE PHARMACIST/PRACTITIONER PORTION

I, _____, do solemnly (swear or affirm) that I am the pharmacist-in-charge acting on behalf of the above facility; and that such Health Department, Private Not-For-Profit Family Planning Clinic, or Indigent Care Clinic will be conducted and operated in full compliance with the Pharmacy Law and professional ethics and all other laws of Kansas so long as continued under such registration. I understand that the registration, if issued, will expire annually on the 30th day of June and such registration will be cancelled if not renewed **annually** by the 31st day of July.

Subscribed in my presence and sworn to before me this _____ day of _____ , 20 ____

(Seal)

_____Signature of Responsible Pharmacist/Practitioner

_____Signature of Notary Republic

My commission expires: _____